



## NOAA DIVING PROGRAM OBSERVER DIVER MEDICAL HISTORY REPORT

### TO THE APPLICANT – PLEASE PRINT CLEARLY

1. Last Name	First Name	Middle Name	2. Date of Birth	3. Age
4. Work Address		a. Work Telephone Number: b. E-mail: c. Cell:		5. Diving Unit
6. Statement of present health.			7. Height	8. Weight
10. List current medications and dosage (note new medications and any dosage changes)			11. Allergies (list all)	

12. PAST/CURRENT MEDICAL HISTORY (Do you currently have or have you ever had the following.)

	Yes	No		Yes	No
Ear trouble including ruptured ear drum, difficulty equalizing, or surgery			Anatomical heart abnormalities including patent foramen ovale, valve problems, etc.		
Decompression sickness, embolism, or other diving malady or injury			Depression, anxiety, claustrophobia, any other psychiatric disorder		
Any treatment in a decompression chamber			Collapsed lung		
Loss of consciousness for any cause			Asthma or breathing problems		
Epilepsy, convulsions, seizures, fits			Other lung diseases		
Stroke or any neurologic deficit			Tuberculosis or positive TB test		
Recurring neurologic disorders including transient ischemic attacks			Exposed to a person with tuberculosis or have persistent cough or sweats		
Aneurysms or bleeding in the brain			Pregnancy		
Trouble with dizziness			Surgery of any kind		
Head injury			Hospitalization for any reason		
Disorders of the blood or easy bleeding			Smoke (if yes, what type and how much)		
Heart disease or high cholesterol			Drink alcoholic beverages (how much)		
High or low blood sugar			Family history of high cholesterol		
Heart rhythm problems			Substance abuse		
Need for a pacemaker			Use of illegal substances		
Problems with blood flow to the heart			Thyroid trouble		
Difficulty with exercise			Bone, joint, or other deformity		
High blood pressure			Any weight gain or loss of 10 pounds or more		

13. Explain in detail any "yes" answers to the questions above.

14. I certify that the above answers and information represent a true, accurate, and complete description of my medical history.

Diver (print)	Signature	Date
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15. Examiner summary of defects.

16. Signature certifies the examiner has reviewed the above medical history and found no contraindications to scuba diving.

Examiner (print)	Title (MD/DO/NP/PA only)	Signature	Date
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